HEALTH CARE FOR THE UNINSURED

FINDING: Louisiana's current approach to indigent health care lacks a comprehensive understanding of the health care needs of the state, and should be redirected to achieve specific policy priorities and outcomes, such as reducing the number of people who lack health insurance coverage, increasing access to community-based and primary health care, reducing excess hospital capacity, and improving the state's low health status rankings.

- Louisiana has the 3rd highest percentage of its population without health insurance coverage in the nation, and that percentage is on the rise.
- One reason for the large number of uninsured is a large a low-income population in the state.
- For many low-income people, private coverage is either unavailable or unaffordable.
- State Medicaid coverage or "free care" from hospitals, doctors, clinics or other providers is the only option for a number of low-income people.
- Medicaid covers only a fraction of Louisiana's low-income population, because the state has chosen to expand Medicaid eligibility only modestly beyond the federal minimum requirements.
- The state relies on a limited number of "safety net" hospitals to meet the health care needs of those without insurance, and makes direct payments to those hospitals for the uncompensated cost of indigent care.
- The state's hospital-based approach to indigent care inadequately addresses a number of issues, including excess hospital capacity and a shortage to community-based and primary health care in Louisiana.
- The state's high uninsured rate may contribute to its low health status rankings.

(See Appendix for two issue briefs which explain the above findings and following options in greater detail, *Issue Brief on Health Care for the Uninsured* - pp. 39-42 and *Issue Brief on Primary Health Care* – pp. 43-44.)

OPTION 1: Expand Medicaid/LaCHIP eligibility to narrow the gap in health insurance coverage between children and adults.

In 1999, children comprised less than one-third of Louisiana's total uninsured population. Since mid-1999, the state has invested in the LaCHIP program to expand Medicaid eligibility for children with family income up to 200% of poverty (low-income families). Last year, children in low-income families accounted for more than half (51%) of all children in the state. It is projected that the LaCHIP expansion will have covered 90,000 children by the end of this calendar year, making it likely that by 2002 children will account for an even smaller proportion of total population lacking health insurance in the state.

The vast majority of Louisiana's uninsured are adults, reflecting that Medicaid eligibility for non-disabled (non-pregnant) adults is limited to parents of minor children with income up to 20% of poverty. Pregnant women with incomes less than 133% of poverty are Medicaid eligible. Childless couples and single adults are not eligible for Medicaid at any income level. These eligibility limits reflect the pre-welfare reform era, despite recent changes in federal law that encourage the transition from welfare to work by allowing states to expand Medicaid eligibility to low-income working parents.

Both Medicaid and CHIP funds may now be used to pay for Medicaid coverage for low-income working parents. Nationally, parents of CHIP kids account for more than half of the adult uninsured population. Their coverage in Louisiana could narrow the gap in health insurance coverage between children and adults and substantially reduce the state's uninsured rate overall. It could also improve child health in light of recent research showing that children get better heath care when parents are also insured.

Expanded Medicaid coverage to the uninsured could improve the state's health status rankings. Research shows that the uninsured are less likely to get preventative and primary care, less likely to have continuity of care, more likely to be diagnosed and treated at a later stage of illness, more likely to be hospitalized for avoidable conditions, and have higher death rates.

Medicaid coverage would allow freedom of choice of providers (hospital- or community-based, urban or rural) and coverage of outpatient medications that are essential to maintaining health, two benefits not currently afforded to the uninsured who rely on LSU and other safety net hospitals for their health care.

Estimated Fiscal Impact: Louisiana may be able to expand Medicaid eligibility without additional SGF costs through the use of tobacco settlement revenues, Intergovernmental Transfers (IGTs), and/or reallocations of current uncompensated care (UCC) spending.

An IGT is a contribution to the state from local government that may be used as state match for federal Medicaid or UCC funds. Generally, local government, such as a hospital service district, is motivated to contribute match by the prospect of a direct payment in return. But direct payments are possible only with UCC; by definition UCC payments are paid directly to a hospital for its uncompensated care costs. Local government may be less motivated to contribute match for a Medicaid expansion, because Medicaid participants can choose where they get care and the state has limited ability to direct payments back to the contributor.

Another source of non-SGF funding for a Medicaid expansion is the state match currently budgeted for UCC payments. Because LSU hospitals' primary revenue source is UCC, a Medicaid expansion funded by shifting existing state match from UCC to Medicaid would likely result in a downsizing of the LSU hospitals. This is especially true if LSU loses to other Medicaid providers a significant number of its previously uninsured patients made eligible for Medicaid by the expansion.

Providers cannot be mandated to see Medicaid patients. For a Medicaid card to guarantee access to care, Medicaid payment rates must be set high enough to attract providers. Current payment rates may have to be increased, though in medically underserved areas even higher rates may not ensure adequate access.

Federal Medicaid payments are limited only by the amount a state spends. Administrative and outreach costs are likely to increase with a significant expansion of Medicaid eligibility.

Medicaid is an entitlement, and costs cannot be reduced as easily as payments for UCC.

Action to Implement: An expansion of state Medicaid eligibility could be achieved in a number of ways, the two simplest being 1) an amendment to the state plan and 2) a 1115 CHIP waiver.

Using Section 1931, the state could submit to the federal government an amendment to its state plan that would expand Medicaid eligibility by increasing the current income, asset or work hour limits. Section 1931 relates to federal welfare reform and changes in Medicaid eligibility that facilitate the transition from welfare to work. State plan amendments are not subject to federal approval.

An 1115 CHIP waiver may be used to expand LaCHIP eligibility to include low-income parents. Only children are eligible for coverage under the basic CHIP program, but an 1115 waiver waives the basic rules to allow states to use CHIP funds to cover parents. Unlike state plan amendments, the 1115 waiver is subject to federal approval.

Neither a state plan amendment nor an 1115 waiver requires legislative action, but DHH would likely seek approval from the legislature before it pursued either option. However, any reallocation of state match and related UCC and Medicaid expenditures would have to be made by the legislature, either in the general appropriation bill or in a BA-7 to the Joint Legislative Committee on the Budget.

OPTION 2: Increase or reallocate existing uncompensated care payments to non-state hospitals.

The vast majority of payments for uncompensated care (UCC) costs go to state hospitals. Last fiscal year, 86% of UCC payments went to LSU hospitals, all but one of which is located in an urban area. Only 4% went to non-state hospitals. Half of Louisiana hospitals received no payment for UCC at all, though all provided some level of uncompensated care.

The state's practice of directing UCC payments to a small number of urban hospitals has raised the issue that many indigent uninsured who live in rural areas must travel 30 miles or more to obtain care. Its practice of reimbursing only half of all hospitals for uncompensated care costs has raised issues of equity and hospital solvency.

Increasing or reallocating existing UCC payments to non-state providers could address these issues but would not address other health policy concerns. For example, UCC may only reimburse the uncompensated costs of *hospital-based* care. Not included in hospital-based care are outpatient drugs, doctor's office visits or other community-based health care. A variety of state rankings indicate that LA has too many hospitals and not enough community-based and primary health care. Additional UCC payments are unlikely to address these concerns. Moreover, additional UCC payments to non-state hospitals located in the same locality as state hospitals also receiving UCC could contribute to a duplication of services and help maintain excess hospital capacity.

Estimated Fiscal Impact: Additional UCC payments would require additional state match. Currently Louisiana relies on SGF for match more than other states. Other sources of state match include Intergovernmental Transfers, certified match, and provider fees. Any additional UCC payments should rely on non-SGF sources of state match.

Federal funding for UCC payments is capped. Any UCC spending above the cap would be a 100% state expense, whereas below the cap the state pays only 30% of the UCC total. Congress recently raised the cap, but only slightly. Increased UCC payments could quickly get the state to the new cap, and result in additional SGF liabilities.

Action to Implement: DHH already has the authority to use IGTs and certified expenditures as state match.

State law mandates certain providers pay a fee to participate in the Medicaid program, but hospitals are exempt. A change in state law would be needed to implement a Medicaid provider fee for hospitals.

Additional UCC expenditures would have to be authorized by the Legislature either in the general appropriation bill or in a BA-7 to the Joint Legislative Committee on the Budget.